

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

### Demographics Box

<b>Client Name:</b>	<b>Date:</b>
<b>Current Address:</b> Street City/State Zip Code	<b>Phone #:</b> (     )     -
<b>Date of Birth:</b>	<b>Marital/Relationship Status:</b>
<b>Nation/Tribe/Ethnicity:</b>	
<b>Primary language of client:</b>	<b>Secondary:</b>
<b>Referral Source:</b>	<b>Phone:</b>
<b>Emergency Contact:</b>	<b>Phone:</b>

### Family Relationships

<b>Does the client have any children?</b>						
Name	Age	Date of Birth	Sex	Custody? Y/N	Lives With?	Additional Information
<b>Who else lives with the client? (Include spouses, partners, siblings, parents, other relatives, friends)</b>						
Name	Age	Sex	Relationship	Additional Information		
<b>Primary language of household/family:</b>				<b>Secondary:</b>		

### Critical Population (choose all that apply)

Funding Source	Residential	Legal Involvement	
<input type="checkbox"/> Food Stamp Recipient	<input type="checkbox"/> Homeless	<input type="checkbox"/> Protective Services (APS/CPS)	
<input type="checkbox"/> TANF Recipient	<input type="checkbox"/> Shelter Resident	<input type="checkbox"/> Court Ordered Services	
<input type="checkbox"/> SSI Recipient	<input type="checkbox"/> Long Term Care Eligibility	<input type="checkbox"/> On Probation	
<input type="checkbox"/> SSDI Recipient	<input type="checkbox"/> Long Term Care Resident	<input type="checkbox"/> On Parole	
<input type="checkbox"/> SSA (retirement) Recipient	<b>Disability</b>	<input type="checkbox"/> On Pre-Release	
<input type="checkbox"/> Other Retirement Income		<input type="checkbox"/> Mandatory Monitoring	
<input type="checkbox"/> Medicaid Recipient	<input type="checkbox"/> Physical Disability	<b>Other</b>	
<input type="checkbox"/> Medicare Recipient	<input type="checkbox"/> Severely Mentally Ill		
<input type="checkbox"/> General Assistance	<input type="checkbox"/> SED		<input type="checkbox"/> Currently pregnant
	<input type="checkbox"/> Developmentally Disabled		<input type="checkbox"/> Woman w/dependents
	<input type="checkbox"/> Chronically Mentally Ill		
	<input type="checkbox"/> Regional Behavioral Health Authority		

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

Contact Information (Secure consents for agency contacts, when possible)		
Name of Caseworker	Agency	Phone number

Client's/Family's Presentation of the Problem:
Client's/Family's Expected Outcome:

Physical Realm	Yes	No
Client acknowledges he/she has caused damage to his/her body by abusing drugs, alcohol or food. <b><i>If yes, complete Behavioral Assessment</i></b>		
Client understands the connection between emotions, life stressors, sense of self and the effect these elements have on physical health.		
Client manages his/her anger effectively and does not inflict pain on himself/herself or others.		
Client engages in activities designed to maintain physical health. <b><i>Optional – Physical Fitness</i></b>		
<b>Allergies</b> (Medication and Other):		
<b>Comments:</b>		

### Nutritional Screening

Nutritional Status: Current Weight	Current Height	BMI
<b>Appetite:</b> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor, please explain below		
<input type="checkbox"/> Recently gained/lost significant weight	<input type="checkbox"/> Binges/overeats to excess	
<input type="checkbox"/> Restricts food/Vomits/over-exercises to avoid weight gain	<input type="checkbox"/> Special dietary needs	
<input type="checkbox"/> Hiding/hording food	<input type="checkbox"/> Food allergies	
<b>Comments:</b>		

### Pain Questionnaire

<p><b>Pain Management:</b> Is the client in pain now? <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, ask client to rate the pain on a scale of 1-10 (with 10 being the severest) and enter score here</p> <p style="text-align: center;">Is the client receiving care for the pain? <input type="checkbox"/> Yes <input type="checkbox"/> No          If no, would the client like a referral for pain management? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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### Child/Adolescent Growth & Development

<b>During pregnancy, did the biological mother have any of the following (select all that apply)?</b>			
<input type="checkbox"/> Amniocentesis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes Mellitus	
<input type="checkbox"/> Emotional Problems	<input type="checkbox"/> Excessive weight gain	<input type="checkbox"/> German Measles	
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High fever	<input type="checkbox"/> Kidney problems	
<input type="checkbox"/> No prenatal care	<input type="checkbox"/> Placenta Previa	<input type="checkbox"/> Premature labor	
<input type="checkbox"/> Vaginal bleeding	<input type="checkbox"/> Vaginal infection	<input type="checkbox"/> Other infection	
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other:		
<b>During pregnancy, did the mother use any of the following (select all that apply)?</b>			
<input type="checkbox"/> Tobacco	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Street Drugs	<input type="checkbox"/> Unknown
<b>Comments</b> (frequency and intensity of use, participation in treatment, birth defects or malformations due to drug/alcohol use among siblings):			
<b>Any problems with labor &amp;/or delivery?</b>		<b>Apgar Scores?</b>	
<b>Did the baby have any of the following after delivery (select all that apply)?</b>			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Apnea	<input type="checkbox"/> Birth defects	<input type="checkbox"/> Blood transfusions
<input type="checkbox"/> Bradycardia	<input type="checkbox"/> Cord around neck	<input type="checkbox"/> Eye problems	<input type="checkbox"/> Fever/low temperature
<input type="checkbox"/> Hernia	<input type="checkbox"/> Hydrocephalus	<input type="checkbox"/> Infection	<input type="checkbox"/> Intensive Care
<input type="checkbox"/> Intracranial bleed	<input type="checkbox"/> Jitteriness	<input type="checkbox"/> Physical injury	<input type="checkbox"/> Seizures
<input type="checkbox"/> Surfactant	<input type="checkbox"/> Trouble breathing	<input type="checkbox"/> Trouble sucking	<input type="checkbox"/> 1 of multiples (twin, etc)
<input type="checkbox"/> Use of Oxygen	<input type="checkbox"/> Ventilator	<input type="checkbox"/> Yellow Jaundice	<input type="checkbox"/> Other:
<b>Developmental Milestones – please select any that the client did late or is still having trouble with:</b>			
<input type="checkbox"/> Rolling Over (2-6 months)	<input type="checkbox"/> Sitting (6-12 months)	<input type="checkbox"/> Standing (8-16 months)	
<input type="checkbox"/> Walking (8-16 months)	<input type="checkbox"/> Engaging peers (24-36 months)	<input type="checkbox"/> Toileting (24-36 months)	
<input type="checkbox"/> Dressing self (24-36 months)	<input type="checkbox"/> Feeding Self	<input type="checkbox"/> Sleeping alone	
<input type="checkbox"/> Tolerating separation	<input type="checkbox"/> Playing cooperatively	<input type="checkbox"/> Speaking	
<b>Are immunizations up to date?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Has the client had any of the following (select all that apply)?</b>			
<b>Blood Disorders:</b> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding <input type="checkbox"/> Bruising			
<b>Brain Disorders:</b> <input type="checkbox"/> Confusion <input type="checkbox"/> Headaches <input type="checkbox"/> Coordination Problems			
<input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Staring <input type="checkbox"/> Tremors			
<input type="checkbox"/> Tics (motor/vocal) <input type="checkbox"/> Head Injuries <input type="checkbox"/> Seizures			
<b>GI Problems:</b> <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Soiling <input type="checkbox"/> Vomiting			
<b>Heart/Lung Problems:</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Chest Pain <input type="checkbox"/> Murmur <input type="checkbox"/> Surgery <input type="checkbox"/> Congenital Heart Disease			
<b>Hormone Problems:</b> <input type="checkbox"/> Obesity <input type="checkbox"/> Thyroid <input type="checkbox"/> Early Puberty <input type="checkbox"/> Late Puberty			
<b>Infections:</b> <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> Sinus infections			
<input type="checkbox"/> Ear infections <input type="checkbox"/> Meningitis <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Encephalitis			
<input type="checkbox"/> Mumps <input type="checkbox"/> High fevers <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other:			
<b>Injuries:</b> <input type="checkbox"/> Broken Bones <input type="checkbox"/> Stitches			
<b>Kidney Problems:</b> <input type="checkbox"/> Bed wetting <input type="checkbox"/> Daytime wetting <input type="checkbox"/> Infections			
<b>Muscle/Bone Problems:</b> <input type="checkbox"/> Scoliosis <input type="checkbox"/> Spasticity <input type="checkbox"/> Other:			
<b>Poisoning:</b> <input type="checkbox"/> Chemicals <input type="checkbox"/> Lead <input type="checkbox"/> Other:			
<b>Sensory Problems:</b> <input type="checkbox"/> Hearing <input type="checkbox"/> Tactile <input type="checkbox"/> Vision			
<b>Sexual Problems:</b> <input type="checkbox"/> Birth Control <input type="checkbox"/> Masturbation <input type="checkbox"/> Promiscuity			
<b>Skin Disorders:</b> <input type="checkbox"/> Acne <input type="checkbox"/> Birth Marks <input type="checkbox"/> Eczema <input type="checkbox"/> Hair Loss			

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

### Behavioral Assessment

<b>Abuse/Addiction – Chemical &amp; Behavioral</b>				
Drug	Age First Used	Age Heaviest Use	Recent Pattern of Use (frequency & Amount, etc)	Date Last Used
Alcohol				
Cannabis				
Cocaine				
Stimulants (crystal, speed, amphetamines, etc)				
Methamphetamine				
Inhalants (gas, paint, glue, etc)				
Hallucinogens (LSD, PCP, mushrooms, etc)				
Opioids (heroin, narcotics, methadone, etc)				
Sedative/Hypnotics (Valium, Phenobarb, etc)				
Designer Drugs/Other (herbal, Steroids, cough syrup, etc)				
Tobacco (smoke, chew)				
Caffeine				
<b>Ever injected Drugs?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>If Yes, Which ones?</b>
<b>Drug of Choice?</b>				
<b>Consequences as a Result of Drug/Alcohol Use (select all that apply)</b>				
<input type="checkbox"/> Hangovers	<input type="checkbox"/> DTs/Shakes	<input type="checkbox"/> Blackouts	<input type="checkbox"/> Binges	
<input type="checkbox"/> Overdoses	<input type="checkbox"/> Increased Tolerance (need more to get high)	<input type="checkbox"/> GI Bleeding	<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Seizures	<input type="checkbox"/> Relationship Problems	<input type="checkbox"/> Left School	
<input type="checkbox"/> Lost Job	<input type="checkbox"/> DUIs	<input type="checkbox"/> Assaults	<input type="checkbox"/> Arrests	
<input type="checkbox"/> Incarcerations	<input type="checkbox"/> Homicide	<input type="checkbox"/> Other:		
<b>Longest Period of Sobriety?</b>			<b>How long ago?</b>	
<b>Triggers to use (list all that apply):</b>				
<b>Has client traded sex for drugs?</b>		<input type="checkbox"/> No	<input type="checkbox"/> Yes, explain:	
<b>Has client been tested for HIV?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>If yes, date of last test:</b>			<b>Results:</b>	
<b>Has client had any of the following problem gambling behaviors? Select all that apply:</b>				
<input type="checkbox"/> Gambled longer than planned	<input type="checkbox"/> Gambled until last dollar was gone			
<input type="checkbox"/> Lost sleep thinking of gambling	<input type="checkbox"/> Used income or savings to gamble while letting bills go unpaid			
<input type="checkbox"/> Borrowed money to gamble	<input type="checkbox"/> Made repeated, unsuccessful attempts to stop gambling			
<input type="checkbox"/> Been remorseful after gambling	<input type="checkbox"/> Broken the law or considered breaking the law to finance gambling			
<input type="checkbox"/> Other:	<input type="checkbox"/> Gambled to get money to meet financial obligations			
<b>Risk Taking/Impulsive Behavior (current/past) – select all that apply:</b>				
<input type="checkbox"/> Unprotected sex	<input type="checkbox"/> Shoplifting	<input type="checkbox"/> Reckless driving		
<input type="checkbox"/> Gang Involvement	<input type="checkbox"/> Drug Dealing	<input type="checkbox"/> Carrying/using weapon		
<input type="checkbox"/> Other:				

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

### Leisure & Recreation

<b>Which of the following does the client do? (Select all that apply)</b>			
Spend Time with Friends		Sports/Exercise	
Classes		Dancing	
Time with Family		Hobbies	
Work Part-Time		Watch Movies/TV	
Go "Downtown"		Stay at Home	
Listen to Music		Spend Time at Clubs/Bars	
Go to Casinos		Other:	
<b>What limits the client's leisure/recreational activities?</b>			

### Family History

<b>Family History of (select all that apply):</b>						
	Mother	Father	Siblings	Aunt	Uncle	Grandparents
Alcohol/Substance Abuse						
History of Completed Suicide						
History of Mental Illness/Problems such as:						
Depression						
Schizophrenia						
Bipolar Disorder						
Alzheimer's						
Anxiety						
Attention Deficit/Hyperactivity						
Learning Disorders						
School Behavior Problems						
Incarceration						
Other						
<b>Comments:</b>						

<b>Emotional Realm</b>	<b>Yes</b>	<b>No</b>
Client has an understanding of his/her special relationship to Mother Earth.		
Client has an understanding of his/her relationship with Father Sky.		
Client has a sense of connectedness to the entire universe.		
Client is able to acknowledge all fears, desires, emotions, and feelings of distress & cares for his/her own spirit.		
<b>Additional Information:</b>		

# CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

## Child/Adolescent Educational Assessment

<b>Current educational setting:</b>			
<input type="checkbox"/> Public	<input type="checkbox"/> Tribal	<input type="checkbox"/> Boarding	<input type="checkbox"/> Charter
<input type="checkbox"/> Private	<input type="checkbox"/> Home	<input type="checkbox"/> BIA	<input type="checkbox"/> Vocational
<input type="checkbox"/> Alternate	<input type="checkbox"/> GED	<input type="checkbox"/> College	<input type="checkbox"/> Other
<b>Current grade level:</b> _____ <input type="checkbox"/> Ever skipped a grade or <input type="checkbox"/> been held back? <b>I</b>			
<b>Any testing for an IEP (Individualized Education Plan)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>History of /or current placement in special education?</b>		<b>How many hours per day?</b>	
For learning problems? <input type="checkbox"/> Yes <input type="checkbox"/> No		For behavior problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>History of hyperactivity at school?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		Comment:	
<b>Ever been expelled or suspended?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		Reason:	
<b>School attendance problems:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:			
<b>Other education-related concerns:</b>			

## Functional Assessment

<b>Functional Assessment:</b>	
Is client able to care for him/herself? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain:	
<b>Living Situation:</b>	
<input type="checkbox"/> Housing Adequate	<input type="checkbox"/> Housing Dangerous
<input type="checkbox"/> Housing Overcrowded	<input type="checkbox"/> Incarcerated
<input type="checkbox"/> Ward of State/Tribal Court	<input type="checkbox"/> Homeless
<input type="checkbox"/> Dependent on Others	<input type="checkbox"/> At Risk of Homelessness
Additional Information:	
<b>Uses or Needs assistive or adaptive devices (select all that apply):</b>	
<input type="checkbox"/> None	<input type="checkbox"/> Glasses
<input type="checkbox"/> Hearing Aids	<input type="checkbox"/> Cane
<input type="checkbox"/> Walker	<input type="checkbox"/> Crutches
<input type="checkbox"/> Braille	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Translated Written Information	<input type="checkbox"/> Translator for Speaking
<input type="checkbox"/> Other:	
Does the client have a history of falls? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	

## Legal Status Screening

<b>Past or current legal problems (select all that apply)?</b>		
<input type="checkbox"/> None	<input type="checkbox"/> Gangs	<input type="checkbox"/> DUI/DWI
<input type="checkbox"/> Arrests	<input type="checkbox"/> Conviction	<input type="checkbox"/> Detention
<input type="checkbox"/> Jail	<input type="checkbox"/> Probation	<input type="checkbox"/> Other
<b>If yes to any of the above, please explain:</b>		
<b>Any court-ordered treatment?</b> <input type="checkbox"/> Yes (explain below) <input type="checkbox"/> No		
<b>Ordered by</b>	<b>Offense</b>	<b>Length of Time</b>

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

### Family Social History

**Describe family relationships & desire for involvement in the treatment process:**

**Perceived level of support for treatment? (scale 1-5 with 5 being the most supportive)**

Spiritual Self	Yes	No
Client demonstrates a willingness to seek out new persons, places and experiences.		
Client expresses a desire to make a positive life change.		
Client seeks to balance his/her rights, needs and desires with those of others in order to achieve harmony.		
Client desires personal harmony, balance and freedom.		
Client seeks to strengthen his prayer life/belief system.		
<b>Additional Information:</b>		

### Bereavement/Loss & Spiritual Awareness

**Please list significant losses, deaths, abandonments, traumatic incidents:**

#### Spiritual/Cultural Awareness & Practice

**Knowledgeable about traditions, spirituality, or religion?**       Yes       No

Comment:

**Practices traditions, spirituality, or religion?**       Yes       No

Comment:

**How does client describe his/her spirituality?**

**Does client see a traditional healer?**       Yes       No

Comment:

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

### Abuse/Neglect/Exploitation Assessment

History of neglect (emotional, nutritional, medical, educational) or exploitation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.			
Has client been abused at any time in the past or present by family, significant others, or anyone else?) <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:			
Type of Abuse	By Whom	Client's Age(s)	Currently Occurring? Y/N
Verbal Putdowns			
Being threatened			
Made to feel afraid			
Pushed			
Shoved			
Slapped			
Kicked			
Strangled			
Hit			
Forced or coerced into sexual activity			
Other			
Was it reported? <input type="checkbox"/> Yes <input type="checkbox"/> No	To whom?		
Outcome			
Has client ever witnessed abuse or family violence? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:			

Mental/Introspective Thought	Yes	No
Client believes that he is speaking honestly with him/herself.		
Client looks at both problems & accomplishments as an indicator of his/her sense of self		
Client examines the ways in which he/she has tried to manipulate, control or manage the lives of others.		
Client acknowledges that changes in his/her life must start with him/her.		
<b>Additional Information:</b>		

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

<b>Strengths/Resources</b> (enter score if present) <b>1 = Adequate, 2 = Above Average, 3 = Exceptional</b>		
Family Support	Social Support Systems	Relationship Stability
Intellectual/Cognitive Skills	Coping Skills & Resiliency	Parenting Skills
Socio-Economic Stability	Communication Skills	Insight & Sensitivity
Maturity & Judgment Skills	Motivation for Help	Other:
<b>Comments:</b>		
<b>Describe appropriateness &amp; level of need for the family's participation:</b>		

### Mental Status Exam

Category	Selections
<b>GENERAL OBSERVATIONS</b>	
<b>Appearance</b>	<input type="checkbox"/> Well groomed <input type="checkbox"/> Unkempt <input type="checkbox"/> Disheveled <input type="checkbox"/> Malodorous
<b>Build</b>	<input type="checkbox"/> Average <input type="checkbox"/> Thin <input type="checkbox"/> Overweight <input type="checkbox"/> Obese
<b>Demeanor</b>	<input type="checkbox"/> Cooperative <input type="checkbox"/> Hostile <input type="checkbox"/> Guarded <input type="checkbox"/> Withdrawn
	<input type="checkbox"/> Preoccupied <input type="checkbox"/> Demanding <input type="checkbox"/> Seductive
<b>Eye Contact</b>	<input type="checkbox"/> Average <input type="checkbox"/> Decreased <input type="checkbox"/> Increased
<b>Activity</b>	<input type="checkbox"/> Average <input type="checkbox"/> Decreased <input type="checkbox"/> Increased
<b>Speech</b>	<input type="checkbox"/> Clear <input type="checkbox"/> Slurred <input type="checkbox"/> Rapid <input type="checkbox"/> Slow
	<input type="checkbox"/> Pressured <input type="checkbox"/> Soft <input type="checkbox"/> Loud <input type="checkbox"/> Monotone
Describe:	
<b>THOUGHT CONTENT</b>	
<b>Delusions</b>	<input type="checkbox"/> None Reported <input type="checkbox"/> Grandiose <input type="checkbox"/> Persecutory <input type="checkbox"/> Somatic
	<input type="checkbox"/> Bizarre <input type="checkbox"/> Nihilist <input type="checkbox"/> Religious
Describe:	
<b>Other</b>	<input type="checkbox"/> None Reported <input type="checkbox"/> Poverty of Content <input type="checkbox"/> Obsessions <input type="checkbox"/> Compulsions
	<input type="checkbox"/> Phobias <input type="checkbox"/> Guilt <input type="checkbox"/> Anhedonia <input type="checkbox"/> Thought Insertion
	<input type="checkbox"/> Ideas of Reference <input type="checkbox"/> Thought Broadcasting
Describe:	
<b>Self Abuse</b>	<input type="checkbox"/> None Reported <input type="checkbox"/> Self Mutilization
	<input type="checkbox"/> Suicidal (assess lethality if present) <input type="checkbox"/> Intent <input type="checkbox"/> Plan
<b>Aggressive</b>	<input type="checkbox"/> None Reported <input type="checkbox"/> Aggressive (assess lethality of present)
	<input type="checkbox"/> Intent <input type="checkbox"/> Plan
<b>PERCEPTION</b>	
<b>Hallucinations</b>	<input type="checkbox"/> None Reported <input type="checkbox"/> Auditory <input type="checkbox"/> Visual
	<input type="checkbox"/> Olfactory <input type="checkbox"/> Gustatory <input type="checkbox"/> Tactile
Describe:	
<b>Other</b>	<input type="checkbox"/> None Reported <input type="checkbox"/> Illusions <input type="checkbox"/> Depersonalization <input type="checkbox"/> Derealization
<b>THOUGHT PROCESS</b>	
<input type="checkbox"/> Logical	<input type="checkbox"/> Goal Oriented <input type="checkbox"/> Circumstantial <input type="checkbox"/> Tangential
<input type="checkbox"/> Loose	<input type="checkbox"/> Rapid Thoughts <input type="checkbox"/> Incoherent <input type="checkbox"/> Concrete
<input type="checkbox"/> Blocked	<input type="checkbox"/> Flight of Ideas <input type="checkbox"/> Perserverative <input type="checkbox"/> Derailment
Describe:	
<b>MOOD</b>	
<input type="checkbox"/> Euthymic	<input type="checkbox"/> Depressed <input type="checkbox"/> Anxious
<input type="checkbox"/> Angry	<input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable
<b>AFFECT</b>	
<input type="checkbox"/> Flat	<input type="checkbox"/> Inappropriate <input type="checkbox"/> Labile <input type="checkbox"/> Blunted
<input type="checkbox"/> Congruent with Mood	<input type="checkbox"/> Full <input type="checkbox"/> Constricted

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<b>BEHAVIOR</b>			
<input type="checkbox"/> No behavior issues	<input type="checkbox"/> Assaultive	<input type="checkbox"/> Resistant	
<input type="checkbox"/> Aggressive	<input type="checkbox"/> Agitated	<input type="checkbox"/> Hyperactive	
<input type="checkbox"/> Restless	<input type="checkbox"/> Sleepy	<input type="checkbox"/> Intrusive	
<b>MOVEMENT</b>			
<input type="checkbox"/> Akathisia	<input type="checkbox"/> Dystonia	<input type="checkbox"/> Tardive Dyskinesia	<input type="checkbox"/> Tics
Describe:			
<b>COGNITION</b>			
<b>Impairment of:</b>	<input type="checkbox"/> None Reported		<input type="checkbox"/> Orientation
	<input type="checkbox"/> Attention/Concentration		<input type="checkbox"/> Ability to Abstract
	Describe:		
<b>Intelligence Estimate</b>	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Borderline	<input type="checkbox"/> Average
<b>IMPULSE CONTROL</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> Absent
<b>INSIGHT</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> Absent
<b>JUDGMENT</b>	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> Absent

<b>RISK ASSESSMENT</b>				
<b>Risk to Self</b>	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	<input type="checkbox"/> Chronic
<b>Risk to Others</b>	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	<input type="checkbox"/> Chronic
<b>Serious current risk of any of the following: (Immediate response needed)</b>				
<b>Abuse or Family Violence</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Abuse or Family Violence</b>
				<input type="checkbox"/> Yes
				<input type="checkbox"/> No
<b>Psychotic or Severely Psychologically Disabled</b>				
<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Is there a handgun in the home?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Any other weapons?</b>
				<input type="checkbox"/> Yes
				<input type="checkbox"/> No
<b>Plan:</b>				
<b>Safety Plan Reviewed</b>				
<input type="checkbox"/> Yes <input type="checkbox"/> No				

### Diagnoses and Interpretive Summary

<b>Biopsychosocial formulation</b>	
<b>DSM IV-TR Provisional Diagnoses</b>	
<b>Axis I</b>	
<b>Axis II</b>	
<b>Axis III</b>	
<b>Axis IV</b>	
<b>Axis V</b>	
<b>Treatment Acceptance/Resistance</b>	
<b>Client accepts problem?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Comment:</b>	
<b>Client recognizes need for treatment?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Comment:</b>	
<b>Client minimizes or blames others?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Comment:</b>	
<b>External motivation is primary?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Comment:</b>	

# CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

## Preliminary Treatment Plan & Referrals

Preliminary Biopsychosocial Treatment Plan			
<b>Biological:</b>			
<b>Psychological:</b>			
<b>Social/Environmental:</b>			
Referrals			
<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Psychologist	<input type="checkbox"/> Medical Provider	<input type="checkbox"/> Spiritual Counselor
<input type="checkbox"/> Benefits Coordinator	<input type="checkbox"/> Nutritionist	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Vocational Counselor
<input type="checkbox"/> Social Worker	<input type="checkbox"/> Community Agency:		<input type="checkbox"/> Other:

### Physical Fitness (optional)

<p><b>Physical Activity (please select one of the following based on activity level for the past month):</b></p> <p><input type="checkbox"/> Avoids walking or exertion, e.g. always uses elevator, drives whenever possible instead of walking.</p> <p><input type="checkbox"/> Walks for pleasure, routinely uses stairs, occasionally exercises sufficiently to cause heavy breathing or perspiration.</p> <p>Participates regularly in recreation or work requiring <b>modest physical activity</b> such as golf, horseback riding, calisthenics, gymnastics, table tennis, bowling, weight lifting, and yard work.</p> <p><input type="checkbox"/> 10-60 minutes per week</p> <p><input type="checkbox"/> More than one hour per week</p> <p>Participates regularly in <b>heavy physical exercise</b>, such as running, jogging, swimming, cycling, rowing, skipping rope, running in place or engaging in vigorous aerobic activity such as tennis, basketball or handball.</p> <p><input type="checkbox"/> Runs less than a mile a week or engages in other exercise for less than 30 minutes per week</p> <p><input type="checkbox"/> Runs 1-5 miles per week or engages in other exercise for 30-60 minutes per week</p> <p><input type="checkbox"/> Runs 5-10 miles per week or engages in other exercise for 1-3 hours per week</p> <p><input type="checkbox"/> Runs more than 10 miles per week or engages in other exercise for more than 3 hours per week</p>
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